Section 1 - Introduction and Executive Summary

Background

Congress enacted Title XXI, the State Children's Health Insurance Program (S-CHIP), with the express purpose of "providing states with the resources, flexibility, and tools they need to expand the provision of coverage and services to uninsured low income children."[1] The State of Minnesota has a long history of commitment, through public involvement, market reform, and state-subsidized programs, to reducing the rate of uninsurance in Minnesota, especially among children. President Clinton himself acknowledged that "Minnesota has shown exceptional leadership in implementing policies that ensure low-income children have access to meaningful, affordable health care," and that the MinnesotaCare Program was used as a model in designing S-CHIP.[2]

Through Medicaid Program expansions in the late 1980's and the Children's Health Plan, established in 1987 and renamed the MinnesotaCare Program in 1992, and through the health care reforms that began in the early 1990's, Minnesota has effectively reduced the rate of uninsurance, assisted many families on AFDC and TANF in moving into the work force, and has provided an option for people without reasonable means to obtain health care for their children. From 1990 to 1999, the rate of uninsurance among children under age 18 decreased significantly from 5.3 percent to 3.4 percent. We know that MinnesotaCare has not had a negative impact on the rate of insurance--there has been no measurable "crowd-out" effect despite the high income standards in this program.[3] During the same period, the national rate was rising.

In July 1995, the Health Care Financing Administration (HCFA) greatly enhanced Minnesota's efforts by granting approval of the MinnesotaCare Health Care Reform Waiver, which provided federal Medicaid funds for expenditures on behalf of pregnant women and children enrolled in MinnesotaCare. Due in part to the federal contribution, Minnesota has been able to improve the MinnesotaCare Program by increasing income standards and by expanding the benefit package.

Title XXI was designed to assist states to reduce the rate of uninsurance among lower-income children, but the funding is primarily available for states that provide coverage for children at income levels above their current income standards. Raising the income standard above the existing level--275% of poverty--is not the best solution to addressing the needs of uninsured children in this State. We have 48,000 uninsured children under age 19 in this State, approximately two-thirds of whom are in families with income below 200% of federal poverty. Many of them are eligible but not enrolled in the existing programs. Others are not eligible

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[1] *State Children's Health Insurance Program (S-S-CHIP) Implementation Guide,* Chainnan Tom Bliley, House Committee on Commerce, November 1997.

[2] Letter of December 6, 1999 from President Clinton to Governor Ventura.

[3] Call, K.T., *et al..*, "Who Is Still Uninsured in Minnesota? Lessons from State Reform Efforts," *Journal of the American Medical Association,* October 8, 1997, Vol. **278,** No. **14.**

because our program is not as generous as other state S-CHIP programs, both in the premium structure and the "anti-crowd-out" features. Our focus in Minnesota must be on reaching those remaining low-income uninsured children.

In addition, there are other needs that should be addressed. We know that racial and ethnic minorities in Minnesota have higher rates of uninsurance, in particular Hispanic people. We also know that American Indians experience higher rates of uninsurance. While we have been successful at reducing chronic uninsurance in Minnesota, we know we have been less successful at reducing the number of people who frequently move on and off of insurance.

Project Proposal

We acknowledge that Congress intended S-CHIP funding to be used to expand enrollment for uninsured children. Minnesota intends to maintain its existing efforts in providing health care to children. But at the same time, Congress created allotments to individual states that were intended to address unmet needs of states. These allotments were already weighted downward for states like Minnesota with lower rates of uninsurance. Minnesota should not be expected to expand coverage and address the unmet need without the use of the S-CHIP funds. We therefore propose the following expansions to our programs, that are targeted toward the real unmet need in this State, without requesting the refinancing of MinnesotaCare under S-CHIP, as we did in our first waiver request.

- **Enrollment.** Expenditures related to the number of children enrolled in MinnesotaCare above baseline enrollment will be matched at the S-CHIP rate, and will count against the S-CHIP allotment. The baseline is defined as the number of children under age 19 enrolled in MinnesotaCare in September, 1998, which is the month in which our S-CHIP state plan became effective.

- **Presumptive Eligibility.** We propose to introduce the use of presumptive eligibility for all children under age 19 who apply for either MA or MinnesotaCare. The expenditures related to the additional eligibility months will be matched at the S-CHIP rate and will count against the allotment. This change requires enactment by the Legislature, and therefore would not be effective until October 1, 2001.

- **Coverage for MinnesotaCare Parents.** Parents and caretakers enrolled in MinnesotaCare with income above 100% of the federal poverty guidelines, and at or below 275% of poverty, will be matched at the S-CHIP rate. This change would be effective immediately.

- **Premiums.** We propose to reduce MinnesotaCare premiums so that they do not exceed the Title XXI maxima. That involves eliminating the premiums for children in families with income below 150% of poverty, and capping the existing premium schedule at 5% of family income, and eliminating premiums for American Indian people. This change

requires enactment by the Legislature, and therefore would not be effective until October 1,2001.

- **Special Health Initiatives.** We propose to use the remainder of the allotment for special health initiatives designed to improve the health of low-income children that fit within Minnesota's Public Health Improvement Goals 2004 for children and adolescents. We have identified a number of projects currently underway to improve access to dental care and to improve the identification and treatment of children with mental health needs. We have also identified a number of areas of need that will serve as the basis for development of new special health initiatives, such as reducing exposure to lead poisoning, and reducing the disparity in health outcomes among ethnic and racial minority populations. We will reserve all federal revenue earned from the expansions and initiatives under this demonstration to be used for the improvement of children's health. Also, we will develop a procedure for the development of new initiatives that will involve participation from the public, consumers, advocates, providers, other government agencies, and the Legislature.

Evaluation

States that are now just starting programs similar to MinnesotaCare will be, within a few years, in the same place that Minnesota is now. Minnesota provides an ideal opportunity to demonstrate and evaluate a variety of approaches to address the health care needs of children who remain uninsured. A number of questions could be answered, such as:

- Are there methods, such as targeted health initiatives and direct provider payments that are more effective than insurance products in reducing the disparity in health outcomes for racial and ethnic minority populations?
- What can we do to create continuity of care for those that do cycle on and oft?
- What methods of outreach are more effective than others?
- What are the reasons that people who know about the program do not apply for it, and how can this be addressed?
- Is there a "natural rate" of uninsurance that will be reached, at which point unmet needs have to be met outside of a plan of insurance?

We cannot use Minnesota's **$28** million annual allotment to answer these and other questions without HCFA's assistance.

Conclusion

MinnesotaCare has contributed greatly to the collective knowledge in this country about the

uninsured--most notably, how to reduce the rate of insurance without negative impact on the rate of private insurance, and how to provide a safety net to prevent people from falling into greater dependency. But there is much to learn. Through the help of communities, advocates, health care professionals, consumers, academics, local governments, and the federal government, we can learn and do more. Minnesota's uninsured children should not be disadvantaged because the Title XXI allotment is not available to them.